



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

JACK P MITCHELL

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-1326-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 13, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 133.304(k) this facility and or it's licensed health care provider(s) is required to notify the carrier that it is dissatisfied with the carrier's final action on the enclosed medical bill(s). Therefore, the sender of the medical bill(s) is officially requesting the carrier to reconsider its action on the enclosed medical bill(s) because the health care provider(s) or facility is dissatisfied. Also per the above mentioned rule the sender is submitting this information via FAX ... Our Position for Necessity of services and Rebuttal to Carrier's Position Item 1) DOS 06-06-2013, code 99456-WP-MI (8) represents disability exam with multiple impairments. Pursuant to DWC Rule 127.10 (d), when the extent of injury may not be agreed upon by the parties, the designated doctor shall provide multiple certifications o MMI and Impairment rating from which to pay benefits as required by the ACT."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed for eight impairment ratings to the left knee. Texas Mutual inadvertently paid for one. Now the requestor seeks additional payment for seven impairment ratings to the left knee. Texas Mutual denied payment for the following reason. Rule 134.204 (j)(4)(B) states, "When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 06, 2013	CPT Code 99456-WP-MI	\$350.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

Issues

1. Did the requestor bill the disputed service in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (i)(1) (j) states Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include: (A) the examination; (B) consultation with the injured employee; (C) review of the records and films; (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and, (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits). (4) The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

Review of submitted documentation provided by the requestor finds no examination, records or reports to support the service billed for disputed service June 06, 2013.

2. The respondent issued payment in the amount of \$50.00. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	08/29/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.